MONTH-END AGENCY REIMBURSEMENT INVOICE FOR CARE/HIPP ENROLLMENT SERVICES

PART I

To: California Department of Public Health
Office of AIDS
ATTN: CARE/HIPP
P.O. Box 997426, MS 7700
Sacramento, CA 95899-7426

From: Organization name: _____

Mailing address: _____

_____

_____

Expense period: _____ Federal Tax ID Number: _____

Original enrollments	_____	(@ $25.00 each)	$ _____
Recertifications	_____	(@ $25.00 each)	$ _____
HIPP transitions (by the 12th month)	_____	(@ $100.00 each)	$ _____
HIPP transitions (after the 12th month)	_____	(@ $75.00 each)	$ _____
		Total this invoice:	$ _____

I hereby certify that the amount claimed is accurate and a true representation of the amount owed. I have attached the **required** client documentation for each claim. **I understand that failure to provide the required documentation for each claim will result in nonreimbursement.**

_____ _____ _____
Authorized signature (fiscal representative) Title Date

The Ryan White HIV/AIDS Treatment Modernization Act, allows the California Department of Public Health, Office of AIDS, to authorize the above administrative payment(s), in the amount shown, for the specified period, and to the payee as indicated.

_____ _____
Authorized signature Date

MONTH-END AGENCY REIMBURSEMENT INVOICE
CARE/HIPP REFERRAL
PART II

*Client Last Name, First Initial	Enrollment Date	Recertification Date	HIPP Transition Date
TOTALS			

**Do not* enter the full name of the client.